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Committee on Energy and Commerce

Hearing on the Federal Government's
Partnership with America's Pharmacists

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Chairman Deal, Ranking Member Brown and distinguished Committee Members:

Thank you for the opportunity to testify today as a representative of the long term care pharmacy community. I am a pharmacist by training and the president of a specialized pharmacy company that serves residents of long term care facilities in Ohio and Kentucky. Our company's pharmacists are experts in the field of pharmaceutical care for the frail elderly and have been working on the "front lines" to assist in implementing the new Medicare prescription drug benefit.

The long term care pharmacy community strongly supported the goals of the 2003 Medicare Modernization Act (MMA) to expand access to prescription drug coverage for all Medicare beneficiaries. While many of the MMA's provisions focused on beneficiaries who reside outside institutional settings, the Act also included important protections for vulnerable residents of nursing facilities.

Long term care pharmacies have worked in close partnership with the Centers for Medicare and Medicaid Services (CMS) to identify and solve the inevitable problems associated with the introduction of a major new benefit under the Medicare program. Like other pharmacy providers, long term care pharmacies have been severely impacted by extended delays in payments from prescription drug plans, as well as a multitude of burdensome documentation requirements that vary widely among plans.

CMS has issued important guidance to implement appropriate protections and ensure long term care residents' access to necessary medications. We commend the Agency for its attention to these issues, however, a number of significant concerns remain unresolved. We look forward to working with this Committee and the Agency to address those challenges.

Overview

The typical nursing home resident is 84 years of age, female, has seven distinct diagnoses, and takes approximately eight different drugs at any given time. The patients we serve are among the oldest and sickest Medicare beneficiaries, and until January 2006, a majority received their drug coverage through State Medicaid programs. On average, 70 percent of nursing home residents received drug coverage under Medicaid, another 15 percent received

coverage under Medicare Part A, and the remaining 20 percent either were private pay patients or covered by a third-party plan.

This situation changed dramatically on January 1, 2006, when dual eligible beneficiaries were auto-enrolled randomly in plans with premiums at or below the benchmark amount. The 70 percent of nursing home residents who are dually eligible for Medicaid and Medicare may now be enrolled in as few as six or as many as 16 different prescription drug plans. As a result, long term care pharmacists face a daunting task in attempting to manage these patients' drug regimens across a wide variety of plans' formularies.

As implementation of Medicare Part D continues, several "course corrections" are needed to ensure that residents of long term care facilities continue to receive the specialized pharmacy benefits anticipated under the program.

Network Access

Unlike beneficiaries residing outside institutional settings, long term care residents do not go to the pharmacy – the pharmacy comes to them. For that reason, a "retail" standard of access is inappropriate for long term care patients. To ensure access nursing home residents' access to necessary medications, the MMA authorized CMS to establish long term care pharmacy network standards for prescription drug plans.

However, CMS has not developed an objective standard to evaluate the adequacy of a plan's long term care pharmacy network. As late as November 2005, CMS continued to encourage plans to contract with long term care pharmacies to ensure convenient access to necessary services.

Under guidance issued by CMS in March 2005, plans were required to provide a list of enumerated services to residents of long term care facilities[1]. CMS expected plans to contract with pharmacies that could certify their ability to provide these services. In theory, each of the participants in these negotiations had equal incentive to compromise: the pharmacies needed access to provide services to nursing home residents, and the plans needed in-network pharmacies to fulfill their obligations for convenient access.

As the negotiations progressed, however, it soon became clear that the pharmacies had much less bargaining power than the plans. If a nursing home resident was enrolled in a plan that did not include the facility's long term care pharmacy in network, the pharmacy was forced to agree to the plan's standard agreement in order to provide services to the beneficiary. Even if the beneficiary changed to a plan that included the pharmacy in network, the new assignment would not take effect until the first day of the following month. As a result, many pharmacies were forced to accept plans' default provider agreements to avoid a lapse in coverage for beneficiaries in long term care facilities, particularly those in rural areas.

To remedy this problem, CMS should allow changes in beneficiaries' coverage to take effect immediately upon enrollment in a new plan. This approach would ensure

[1] Centers for Medicare and Medicaid Services: *Long Term Care Guidance* (March 16, 2005).

beneficiaries' continued access to necessary pharmacy services without imposing undue hardship on plans.

CMS Marketing Guidelines

In implementing Part D, CMS has gone to significant lengths to protect beneficiaries from unethical and overly aggressive marketing techniques that raise the potential for conflicts of interest. Long term care pharmacies strongly support this objective. At the same time, beneficiaries must have access to useful information necessary to select the best plan to meet their needs. Unfortunately, efforts by CMS to protect beneficiaries have made it almost impossible to help nursing home residents choose an appropriate plan.

CMS issued its guidance on marketing activities last summer.[2] This guidance is extremely prescriptive and effectively prevents long term care residents from receiving specific advice in selecting their drug plans. The simple act of suggesting to a beneficiary that certain drug plans are more responsive to the needs of long term care residents is, by CMS standards, considered a violation of the marketing guidelines.

CMS officials have expressed repeated concern that health care providers will recommend plans based on their own financial interest rather than on the interest of the beneficiary. Yet beneficiaries face a multitude of plan choices, and a recent analysis by the Kaiser Family Foundation[3] highlighted significant differences among plan formularies. Clearly, some plans are more appropriate for residents of long term care facilities. Professional caregivers should be able to communicate this information to beneficiaries, while emphasizing that they are free to choose the plan they prefer.

Compounding this problem, CMS recently issued a letter to state nursing home surveyors[4] outlining their responsibility to inspect nursing homes for evidence of steering, coaching, or requesting residents to select or change plans for any reason. This document has served to raise the stakes among nursing home operators for any well-intended effort to help residents choose an appropriate Part D plan.

Given the frail medical condition and high level of cognitive impairment among residents of long term care facilities, CMS should allow professional caregivers to provide recommendations on plan selection to Medicare beneficiaries, while assuring them of their right to choose whatever plan they prefer. This simple change would enable them to provide effective counseling without undermining residents' freedom to choose any available Part D plan.

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[2] Centers for Medicare and Medicaid Services: *Medicare Marketing Guidelines for: Medicare Advantage Plans (MA); Medicare Advantage Prescription Drug Plans (MA-PD); Prescription Drug Plans (PDP); 1876 Cost Plans* (August 15, 2005).

[3] Hoadley, et al.: *An In-depth Analysis of Formularies and Other Features of Medicare Drug Plans*; Kaiser Family Foundation (April 2006).

[4] Centers for Medicare and Medicaid Services: *Memorandum from Director, Survey and Certification Group to State Survey Agency Directors* (May 11, 2006).

Cost Sharing

Under the MMA's provisions, dual eligible beneficiaries residing in long term care facilities are not required to pay cost sharing for Part D covered drugs. Due to data exchange problems between the states and CMS, however, many dual eligibles were erroneously assigned co-payments under their Part D plans.

In these cases, plans have reimbursed pharmacies at a lower amount after wrongly deducting the cost sharing amounts. To avoid delay in providing needed medicines, long term care pharmacies have typically dispensed the drugs and attempted to resolve the problem later.

CMS continues to work with the states to improve the accuracy of data on dual eligible beneficiaries. In addition, CMS has provided guidance to plans that they may reimburse long term care pharmacies for inappropriately assigned co-payments. This guidance should help resolve historic claims from pharmacies owed reimbursement for uncollected cost sharing, but not all plans are cooperating with efforts to clear up this backlog.

This problem persists, and long term care pharmacies are now owed millions of dollars in improperly-assigned co-payments. While the Agency's efforts to date are commendable, CMS must require plans to act promptly to resolve the significant backlog of uncollected, and improperly assigned, co-payments for dual eligible beneficiaries residing in long term care.

Conclusion

Acknowledging the challenges inherent in implementation of a major new Medicare benefit, the long term care pharmacy community recognizes the importance of the Part D program. We are committed to its success and determined to ensuring that the nation's frail elderly continue to receive the medications they need. Again, thank you for the opportunity to testify today, and I would be glad to answer any questions you may have.